South Carolina Department of Health and Human Services

INCOME TRUST BUDGET SHEET

NURSING FACILITY RESIDENT

Name:_____ Medicaid Number:_____ Date:_____

Effective Date:_____

INCOME		
1. Gross Monthly Income Placed in Trust	$	
2. Gross Monthly Income Received Outside Trust	$	
3. Total Gross Monthly Income		$
ALLOWED DEDUCTIONS		
4. Personal Needs	$	
5. Trust Administration Fee	$	
6. Bank Service Charge	$	
7. Trust Income Tax Due	$	
8. Family Maintenance Allowance/Spousal Allocation	$	
9. Home Maintenance Allowance	$	
10. Health Insurance Premiums	$	
11. Other Allowable Deductions	$	
12. Total Deductions *(4 + 5 + 6 + 7 + 8 + 9 + 10 + 11)*		$
13. Subtotal *(Total Income Less Deductions: 3 - 12)*		$
14. Nursing Facility Monthly Medicaid Rate Facility Name:_____		$
15. Amount to Remain in Trust *(13 - 14)*		$
16. Recurring Income *(Lesser of 13 or 14) Enter on Line 4, Section III, DHHS Form 1296A-ME*		$
ANNUAL ACCOUNTING		
17. Balance in Income Trust Account at the time of previous annual accounting		$
18. Total of amounts that should have remained in Trust each month since time of previous annual accounting		$
19. Amount that should be in the Trust *(17 + 18)*		$
20. Verify actual balance in the Income Trust Account.		$
21. If trustee has not complied with the conditions of the Trust Administration, forward supporting documentation to DHHS Bureau of Eligibility Policy and Oversight.		

NOTE: A COPY OF THIS FORM MUST BE GIVEN TO THE TRUSTEE.

South Carolina Department of Health and Human Services

INCOME TRUST BUDGET SHEET

WAIVER PARTICIPANT

Name:_____ Medicaid Number:_____ Date:_____

Effective Date:_____

INCOME

1. Gross Monthly Income Placed in Trust $_____
2. Gross Monthly Income Received Outside Trust $_____
3. Total Gross Monthly Income $_____

ALLOWED DEDUCTIONS

4. Home Maintenance Needs Allowance *(Amount Equal to Medicaid Cap)* $_____
5. Trust Administration Fee $_____
6. Bank Service Charge $_____
7. Trust Income Tax Due $_____
8. Family Maintenance Allowance/Spousal Allocation $_____
9. Health Insurance Premiums $_____
10. Non-Covered Medical Expenses $_____
11. Other Allowable Deductions $_____
12. Total Deductions *(4 + 5 + 6 + 7 + 8 + 9 + 10 + 11)* $_____
13. Monthly Recurring Income/Cost of Care *(3 - 12)* $_____

ANNUAL ACCOUNTING

14. Balance in income trust account at the time of previous annual accounting $_____
15. Total of amounts that should have remained in trust each month since time of previous annual accounting $_____
16. Amount that should be in the trust *(14 + 15)* $_____
17. Verify actual balance in the income trust account $_____
18. If trustee has not complied with the conditions of the Trust Administration, forward supporting documentation to DHHS Bureau of Eligibility Policy and Oversight.

NOTE: A COPY OF THIS FORM MUST BE GIVEN TO THE TRUSTEE.